



Department of Veterans Affairs

APPLICATION FOR ASSOCIATED HEALTH OCCUPATIONS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. OCCUPATION FOR WHICH APPLYING

- ☐ A CERTIFIED RESPIRATORY THERAPY TECHNICIAN ☐ E LICENSED PHARMACIST ☐ OTHER (Specify):
☐ B REGISTERED RESPIRATORY THERAPIST ☐ F PHYSICIAN ASSISTANT
☐ C LICENSED PHYSICIAN THERAPIST ☐ G EXPANDED-FUNCTION DENTAL AUXILIARY
☐ D LICENSED PRACTICAL/VOCATIONAL NURSE ☐ H OCCUPATIONAL THERAPIST

2. NAME (Last, First, Middle)**3. APPLICATION FOR (Check one)**

- ☐
- GENERAL PRACTICE
- ☐
- SPECIALTY (Identify below)

4. PRESENT ADDRESS (Include ZIP Code)**5. TELEPHONE NUMBER (Include Area Code)****5A. RESIDENCE****5B. BUSINESS****6. DATE OF BIRTH****7. PLACE OF BIRTH****8. SOCIAL SECURITY NUMBER****9A. CITIZENSHIP**

- ☐
- U.S. CITIZEN BY BIRTH
- ☐
- NATURALIZED U.S. CITIZEN
- ☐
- NOT A U.S. CITIZEN (Complete item 9B)

9B. COUNTRY OF WHICH YOU ARE A CITIZEN**10A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA**

- ☐
- YES
- ☐
- NO (If "YES" complete items 10B and 10C)

10B. NAME OF OFFICE WHERE FILED**10C. DATE FILED****11. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER****12. DATE AVAILABLE FOR EMPLOYMENT**

I - ACTIVE U.S. MILITARY DUTY

13A. DATE FROM**13B. DATE TO****13C. SERIAL OR SERVICE NO.****13D. BRANCH OF SERVICE****13E. TYPE OF DISCHARGE**

- ☐
- HONORABLE
- ☐
- OTHER (Explain on separate sheet)

II - LICENSURE, DEA CERTIFICATION AND CLINICAL PRIVILEGES

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED (If not held now, explain on separate sheet)**14B. LICENSE NO.****14C. CURRENT REGISTRATION**

(If "NO" explain on separate sheet)

14D. EXPIRATION DATE**YES****NO****NOT REQUIRED**☐☐☐☐☐☐☐☐☐☐☐☐**15A. ARE YOU FULLY LICENSED IN EVERY STATE IN WHICH YOU RECEIVED A LICENSE (If restricted, limited or probational in any State(s), explain on separate sheet)**

- ☐
- YES
- ☐
- NO
- ☐
- NOT APPLICABLE

15B. DO YOU HAVE PENDING OR HAVE YOU EVER HAD A STATE LICENSE TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUE/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED

- ☐
- YES
- ☐
- NO (If "YES" explain on separate sheet)

15C. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT

- ☐
- YES
- ☐
- NO (If "YES" explain on separate sheet)

16A. NAME THE CERTIFYING BODY FOR YOUR HEALTH OCCUPATION**16B. DATE OF MOST RECENT REGISTRATION/ CERTIFICATION (Give Month and Year)****16C. WHAT IS YOUR REGISTRY/ CERTIFICATION NUMBER****16D. HAS ACTION EVER BEEN TAKEN AGAINST YOUR CERTIFICATION OR REGISTRATION**

- ☐
- YES
- ☐
- NO (If "YES" explain on separate sheet)

17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION

- ☐
- YES
- ☐
- NO (If "YES" complete item 17B)

17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD**17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED**

- ☐
- YES
- ☐
- NO (If "YES" explain on separate sheet)

III - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

► CERTIFICATION: I certify that I have verified licensure and registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).

18. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:

- ☐ CERTIFICATION OR REGISTRATION ☐ VISA
☐ NATURALIZED CITIZENSHIP ☐ CURRENT OR MOST RECENT CLINICAL PRIVILEGES
☐ LICENSURE/REGISTRATION FOR ALL STATES LISTED BY APPLICANT ☐ NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES

19A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE**19B. TITLE****19C. DATE**

IV - PROFESSIONAL LIABILITY INSURANCE

20A. PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER	20B. DATE COVERAGE BEGAN	20C. NAME(s) OF PRIOR CARRIERS	20D. DATES OF COVERAGE		21. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
			FROM	TO	

V - QUALIFICATIONS**BASIC ALLIED HEALTH EDUCATION** (Continue on separate sheet, if necessary)

22A. NAME OF SCHOOL	22B. ADDRESS (City, State and ZIP code)	22C. LENGTH OF PROGRAM	22D. DATE COMPLETED	22E. DIPLOMA OR DEGREE RECEIVED

ADDITIONAL EDUCATION (Continue on separate sheet, if necessary)

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP code)	23C. MAJOR	23D. DATE COMPLETED	23E. CREDITS	23F. DEGREE

VI - PROFESSIONAL EXPERIENCE

24A. EMPLOYER	24B. ADDRESS (City, State and ZIP Code)	24C. POSITION (Where applicable also specify whether General Practitioner or Specialist)	24D. FULL TIME <input type="checkbox"/>	24E. PART-TIME (average hours per week)	24F. DATES EMPLOYED	
					FROM	TO
			<input type="checkbox"/>			
			<input type="checkbox"/>			
			<input type="checkbox"/>			

VI - GENERAL INFORMATION

25. NAMES UNDER WHICH YOU WERE EMPLOYED, IF DIFFERENT FROM NAME GIVEN IN ITEM 1

26. LIST ALL PROFESSIONAL PUBLICATIONS, SCIENTIFIC PAPERS, HONORS, AWARDS, RESEARCH GRANTS, FELLOWSHIPS (If additional space is required, attach separate sheet.)

This is a Free text area, **DO NOT PRESS TAB****VIII - REFERENCES**

27. REFERENCES: List at least four persons living in the United States who are not related to you by blood or marriage and who have been in a position to judge your qualifications during the past five years.

27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NUMBER	27D. BUSINESS OR OCCUPATION

VIII – REFERENCES (Continued)				
27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NUMBER	27D. BUSINESS OR OCCUPATION	

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET OF PAPER	YES	NO
28.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon Military, Federal civilian, or District of Columbia service?	<input type="checkbox"/>	<input type="checkbox"/>
29.	Does the Department of Veterans Affairs employ an relative of your (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.	<input type="checkbox"/>	<input type="checkbox"/>
30.	<p>ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.)</p> <p>(As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proved groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 39, 40 or 41 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 39 or 40, you may omit (1) traffic fines for which you paid a fine or \$100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.</p>			
31.	Within the last five years have you been discharged from any position for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
32.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?	<input type="checkbox"/>	<input type="checkbox"/>
33.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)	<input type="checkbox"/>	<input type="checkbox"/>
34.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 39 above?	<input type="checkbox"/>	<input type="checkbox"/>
35.	While in the military service were you ever convicted by a general court-martial?	<input type="checkbox"/>	<input type="checkbox"/>
36.	If you were in the military service as a physician, dentist, podiatrist or optometrist, did you ever receive a non-judicial punishment (Article 15)?	<input type="checkbox"/>	<input type="checkbox"/>
37.	<p>Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.)</p> <p>If "YES" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.</p>	<input type="checkbox"/>	<input type="checkbox"/>

XI - SIGNATURE OF APPLICANT	
<p>NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).</p>	
<p>► CERTIFICATION: I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.</p>	
38A. SIGNATURE OF APPLICANT (Sign in dark ink)	38B. DATE (Month, Day, Year)

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- Authorize the VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, American medical Association, Federation of State Medical Boards, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom the VA may be referred by those contacted or deemed appropriate;
- Authorize release of such information and copies of related records and/or documents to VA officials;
- Release from liability all those who provide information to the VA in good faith and without malice in response to such inquiries; and
- Authorize the VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable the VA to make such inquiries.

SIGNATURE	DATE
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PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer, 810 Vermont Avenue NW, Washington, DC 20420; and to the Office of Information and Regulatory Affairs (2900-0205) Office of Management and Budget, Washington, DC 20503. Do not send applications to this address.

AUTHORITY: The information requested on the attached application form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determination and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State, or local agency, to the national Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, the American Medical Association, Federation of State Medical Boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also be released without your prior consent to Federal agencies, State licensing boards, the Federation of State Medical Boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from your former employers, education institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.